

The leading voice for hospitals.

## **MHA Guidelines for Emergency Department Opioid Management – Executive Summary and Table of Contents**

The Massachusetts Hospital Association Substance Use Disorder Prevention and Treatment Task Force provide the attached provider focused recommendations to address opioid management within the Emergency Department. While recognizing the need to assess the clinical needs of each patient, these recommendations seek to promote a general standard on opioid utilization and prescribing within Massachusetts Hospital Emergency Departments.

<b>Recommendations</b>	<b>Page</b>
1) Development of processes for substance use screening, brief intervention, and referral to treatment for patients both at risk for developing substance use and patients who actively have substance use disorders.	1-3
2) Consultation with the Massachusetts Prescription Monitoring Program (PMP) before writing an opioid prescription	4-5
3) Utilization of health information exchange systems to share Emergency Department visit history with other ED treating providers.	5
4) Coordination of care processes for patients with high utilization of ER services due to substance use	5-6
5) Emergency Department visit notifications to patient’s primary care or primary opioid prescriber after visit for acute exacerbations of chronic pain	6-7
6) No replacement prescriptions for controlled substances that are lost, destroyed, or stolen or doses of methadone for patients in methadone treatment programs unless specific criteria met	7-9
7) No prescriptions for long-acting or controlled-release opioids, such as OxyContin®, fentanyl patches, and methadone	9
8) Mandatory patient counseling on proper usage, storage, and disposal of opioids when prescribed by Emergency Department staff	9-11
9) Limiting day supply of opioid analgesics for serious acute pain written by Emergency Department Staff, to no more than five days	11-12

Please Note, these recommendations are not intended to interfere with or supersede the professional medical judgment of the provider, nor the clinical and administrative policies of the hospital. Rather, this is intended to provide guidance to clinical staff when seeking to provide the best and safest care to patients within the Emergency Department only.

## **MHA Guidelines for Emergency Department Opioid Management**

The Massachusetts Hospital Association Substance Abuse Prevention and Treatment Task Force set a goal to develop provider-focused strategies within healthcare settings to address opioid misuse. Pursuant to that goal, the task force developed these recommendations for opioid management within the *Emergency Department*. The MHA Board of Trustees unanimously endorsed these recommendations and urges acute care hospitals to consider adopting them. While recognizing the need to assess the clinical needs of each patient, these recommendations seek to promote a general standard on opioid utilization and prescribing within Massachusetts Hospital Emergency Departments.

To assist with implementation, recommendations are followed by general clinical and operational guidance for hospital staff to consider. Providers should be aware of the following four overarching considerations that are integral to the application of each recommendation:

- *The recommendations are not intended to interfere with or supersede the professional medical judgment of the treating provider to determine the right course of treatment (including prescribing practices) based on each individual patient's medical condition;*
- There are instances, documented in the guidance below, where the professional medical judgment of the treating healthcare provider may determine an alternative course of treatment for a specific patient that varies from a recommendation;
- In adopting a recommendation, hospitals may require additional resources for Emergency Department personnel to effectuate the necessary clinical and operational changes; and
- While the task force believes that a patient should obtain opioid medications through one medical clinic or provider to ensure continuity of care, safety, and patient progress, in certain circumstances it may be appropriate to prescribe opioids in a limited manner from the ED.

**1. Hospitals, in conjunction with Emergency Department personnel, should develop a process to screen for substance misuse that includes services for brief intervention and referrals to treatment programs for patients who are at risk for developing, or who actively have, substance use disorders.**

- a. Emergency Department providers work closely with all patients, including those identified as having a higher risk of, or having a history of, prescription or illicit drug misuse or substance use disorder, to ensure they receive an appropriate medical screening examination and clinically appropriate treatment plan (which may include necessary and suitable medication). Providers should always consider alternatives for pain management, including non-pharmacologic treatment (splinting, etc.) and non-opioid medications. In some situations opioid pain medications may be indicated and should be prescribed even to patients with an identified substance use disorder. In these instances, the provider should talk with the patient about the variety of risks, including the increased risk for

substance misuse, addiction, and overdose. If a prescription is offered, the ED provider should refer to recommendation #8, below.

- b. To meet the goal of only prescribing opioid pain medication when necessary, and to curb the high incidence of prescription and/or illicit drug misuse and addiction occurring in communities, it is incumbent upon every hospital to dedicate resources to assist hospital staff in conducting appropriate screenings of patients for substance misuse, addiction, and overdose concerns. This includes providing additional resources for ED staff to develop a written, internal process that documents how providers will screen and discuss interventions (if appropriate) with all patients for whom ED providers are considering writing an opioid pain medication. It also includes providing additional resources for subsequent training and implementation needs. These substance misuse screening processes should not interfere with the hospital's obligations to provide emergency medical screening exams and, if applicable, stabilizing treatment.
- c. Screening tools should be used to assess the patient's risk of substance misuse or use disorder. Screening, in addition to other steps outlined in this recommendation, will help providers make patient-specific treatment decisions and recommendations for follow-up care and/or monitoring. The written process on screening should include a description of all tools that will be used, including validated screening tools, the Prescription Monitoring Program (PMP), or others.
  - i. One example of a process used in some hospitals is the SBIRT (Screening Brief Intervention and Referral to Treatment) process. Studies show that SBIRT is effective in reducing risky alcohol use in adults. Some hospitals use it for brief interventions in an attempt to reduce drug misuse/use disorder, though research is still ongoing in this area. SBIRT aims to identify patients who do not present overtly as moderate or higher risk. General information on this program can be found here:  
<http://www.mass.gov/eohhs/gov/departments/dph/programs/substance-abuse/prevention/screening-brief-intervention-and-referral-to.html>.  
A free webinar about SBIRT use in hospitals is available here:  
<http://hospitalsbirt.webs.com/webinars.htm>.
- d. ED providers see patients ranging from occasional substance users to those who have severe substance use disorders. ED providers have a unique opportunity to intervene with patients who present for medical care. To be effective caregivers and increase the chance of patients following through with recommendations, ED providers should offer patients who could benefit from additional services an easy-to-use list of resources available. The list should include both local and out-of-town services, covering a range of treatment intensity levels and options. The Massachusetts Substance Abuse Information and Education Helpline provides information (free and confidentially) in multiple languages, for all ages, and is available by calling: 1-800-327-5050 or TYY 1-888-448-8321. The helpline has a companion website available at: <http://helpline-online.com/>. Patients, family/friends, or a provider may use this helpline.
- e. While the goal of this recommendation is focused on screening patients who arrive seeking opioid pain medication, the assistance and efforts described above also should be provided to patients who have arrived to the ED due to an overdose of a particular opioid/opiate. These patients should be counseled prior to discharge about overdose and

prevention. If appropriate, patients should be prescribed intranasal naloxone; if someone is accompanying a patient, providers are encouraged to counsel both the patient and the accompanying person that intranasal naloxone must be administered by someone other than the person in overdose. Massachusetts recently changed the law to allow intranasal naloxone to be prescribed to someone in addition to the end user, allowing friends and family members to carry and administer it. If a prescription and/or education are appropriate, providers should consider giving the patient and/or others caring for the patient information on what intranasal naloxone is and how to obtain a prescription. Additionally, patients who arrive to the ED due to an overdose should be referred to follow-up services such as counseling, detoxification, and/or other treatment options as appropriate. The helpline mentioned in the description above (d.) may be helpful to both providers and patients and the following resources may also be useful:

- i. The Massachusetts Department of Public Health's (DPH) Bureau of Substance Abuse Services (BSAS) has a wealth of information on its website for providers, including a directory of substance abuse services, a description of those services, prevention resources, etc., and is available at:  
<http://www.mass.gov/eohhs/gov/departments/dph/programs/substance-abuse/providers/>
- ii. DPH's BSAS also has a general information page on the state's response to the opioid epidemic:  
<http://www.mass.gov/eohhs/gov/departments/dph/programs/substance-abuse/dph-responds-to-opioid-epidemic.html>
- iii. DPH has published an opioid overdose prevention and reversal information sheet, which lists locations where patients can obtain intranasal naloxone:  
<http://www.mass.gov/eohhs/docs/dph/substance-abuse/naloxone-info.pdf>  
Remember that opioid use disorder is a medically based illness just like a severe allergy or uncontrolled diabetes. Opioid use disorders arise from neurologic changes in the nucleus accumbens (the brain's "reward center") that result in loss of control or obsessive use of opioids. Just as an epi-pen can save a patient from an allergic reaction, intranasal naloxone can be a life-saving prescription for patients struggling with chronic opioid use disorder.
  1. For EDs seeking more information on starting an intranasal naloxone program, please see <http://prescribetoprevent.org/>. This site provides a copy of Boston Medical Center's discharge protocol for its program, along with other information and resources that may be helpful.
- iv. Additional free resources available include the SCOPE of Pain, a CME/CNE web-based 3-module activity to help providers manage the prescribing of pain medications and treatment of chronic pain patients, available at:  
<https://www.scopeofpain.com/>. SCOPE of Pain has a list of clinical resources ranging from videos to pain medication information to assessment tools, and those are available at: <https://www.scopeofpain.com/tools-resources/>.
- f. Supporting literature: Madras, et al., Drug and Alcohol Dependence, 2009; 99: 280-95;  
<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2760304/>

**2. When possible, Emergency Department providers, or their delegates, should consult the Massachusetts Prescription Monitoring Program (PMP) before writing an opioid prescription.**

- a. Massachusetts Department of Public Health regulations, which govern when providers ***must*** consult the PMP, provide an exemption to checking the PMP for Emergency Department providers if they are prescribing less than a 5-day supply of a controlled substance (defined as Schedule II and III narcotics, benzodiazepines, and Schedule IV or V controlled substances if indicated in DPH guidance). The MHA Guidelines for Emergency Department Opioid Management not intended to override the DPH regulatory requirement. Rather, it aims to set a baseline standard when providers *should* be consulting the PMP – which is, whenever possible prior to writing an opioid prescription. Given the busy nature of the ED, state regulations correctly provide the flexibility ED providers need to manage patient care and treatment. In short, the PMP should be checked whenever possible, but not when it would interfere with timely and needed medical care or when other circumstances might dictate deviation.
- b. While most ED patients legitimately seek pain relief treatment occurring from injury or exacerbations of other conditions, a minority of people seek opioid medications for inappropriate use because of an addiction or to divert/sell. The PMP was established to collect and disseminate patient prescription histories to individual providers so that the provider can treat and counsel patients appropriately. If it is possible to check the PMP, the information provided can be useful in determining treatment and appropriate follow-up care.
- c. Patterns of concern in the PMP include obtaining medications from multiple providers and filling prescriptions at multiple pharmacies, especially when prescriptions are filled in quick succession or on the same day. Other activities that raise concerns include: obtaining prescriptions from providers in multiple (provider or hospital) systems; obtaining large numbers of pills that may not be warranted given the patient’s height and weight or condition; and filling prescriptions far from the patient’s home address or work address. While these patterns and activities may be concerning, they do not always indicate a misuse issue. Long-term use or high doses do not necessarily indicate a problem, but providers should engage patients to discuss these facts. Patients receiving long-term opioid therapy can develop tolerance, requiring a higher dose of medication.
- d. A concerning pattern of prescriptions in the PMP should NOT be sufficient reason to withhold opioid medication. Patients with obvious sources of pain should be prescribed opioids if indicated. In patients about whom a clinician is uncertain whether a presentation represents “drug seeking behavior” it is recommended to err on the side of providing a limited prescription.
- e. The Massachusetts PMP collects data on dispensed prescriptions of Schedule II-V controlled substances. Once registered, providers can access the past 12 months of a patient’s prescription history. This supports safe prescribing and dispensing practices and aims to curb opioid prescription drug misuse and detect patients with substance use disorder. More information on interpreting and using PMP data is available at: <http://www.mass.gov/eohhs/docs/dph/quality/drugcontrol/prescriber-guide-interpreting-pmp-data.pdf>.
- f. Supporting literature: Hall, et al., JAMA, 2008; 300: 2613-20; Paulozzi, Pain Medicine, 2011; 12: 747-754; Haffajee RL, Jena AB, Weiner SG. Mandatory Use of Prescription Drug

**3. Hospitals should develop a process to share the Emergency Department visit history of patients with other providers and hospitals that are treating the patients in the Emergency Department by using a health information exchange system.**

- a. While it is not currently possible to link all Massachusetts hospital Emergency Departments in real time, this recommendation sets forth a future goal to develop such an interconnected system for all hospitals. Ultimately, all hospitals would directly and immediately share ED patients' visit histories with other EDs and urgent care centers. Information sharing discourages opioid and other drug-seeking behavior and, more importantly, gives ED providers necessary information to appropriately treat incoming patients and refer patients to suitable treatment programs.
- b. Most hospitals within a common system are working toward this goal. As hospitals adopt their policies, they should reflect on how that information is being shared within their system. Once that occurs, there should be discussion about how data are shared or made available to other EDs regarding patients who move from one system to another.
- c. Hospitals must ensure that any developed system meets all appropriate federal and state privacy and security criteria. The task force envisions a system similar to those used in other states. For example, Washington State has created an ED monitoring program similar to the PMP. The ED monitoring program, also known as the Emergency Department Information Exchange (EDIE), allows participating hospitals to share patient visit information through a central database. The database can identify patients with multiple ED visits and shares this information with the ED provider, allowing the provider to determine the appropriate course of treatment and prevent drug-seeking behavior. Washington's system has helped reduce the number of opioid related deaths year after year.

**4. Hospitals should develop a process to coordinate the care of patients who frequently visit Emergency Departments.**

- a. The ED should develop an internal process to identify and provide notice to the patient's primary care provider (PCP), if they have one, that the patient was prescribed or sought opioid medications or was treated for an overdose. The ED should notify the primary care provider of a positive screening for opioid misuse or substance use disorder as well as indicate what information was provided to the patient. This information should be provided in a manner and form determined by each hospital.
- b. ED providers, based on their individual assessment of each patient, should discuss follow-up care that may include referrals to treatment, referrals to social services, and/or follow-up appointments with appropriate groups (internal or external to the hospital). If possible, the follow-up referral should also be documented in the medical record and shared with the PCP when they are notified (per the point above).
- c. Patients should be provided with a list of clinics where they can seek care and, if known prior to discharge, the ED staff should notify the patient of potential insurance requirements (such as prior notice or referrals) if follow up care is recommended.

- d. Supporting literature: Jena, et al., BMJ, 2014; 348: g1393; <http://www.bmj.com/content/348/bmj.g1393.full.pdf+html>.

**5. For acute exacerbations of chronic pain, the Emergency Department provider should notify the patient's primary opioid prescriber or primary care provider of the visit and the medication prescribed.**

- a. ED providers should use caution in prescribing opioids for acute exacerbations of chronic pain, except when clinically appropriate based on the patient's individual medical condition. Providers understand the dangers of drug-to-drug interactions and the importance of knowing if patients have medication(s) in their system or access to other medication(s) prior to prescribing additional medication(s); this may be especially true for chronic pain patients, as they often already have strong pain medication(s) available to them from a primary prescriber. There may be rare occasions where it is clinically appropriate to treat a chronic pain patient with a short-acting opioid medication under observation in the ED during an episode of severe pain. EDs should develop policies to inform the primary opioid prescriber or primary care provider in these circumstances. Opioid therapy should generally be managed through a primary care provider.

Prescribing more than a very short course of opioid medicine in the ED for chronic pain may amount to unmonitored opioid therapy, which would raise significant patient safety concerns. Similarly, changing an opioid medication for a chronic pain patient in an attempt to improve pain relief is also generally not appropriate in the ED, as there is no mechanism for follow up or monitoring and no relationship/responsibility as a primary prescriber. There may be circumstances, however, where the provider's professional medical judgment supports a different opioid medication to treat an episode of acute pain that is not responding to the patient's usual treatment regimen. The following are general safeguards the treating provider should consider prior to prescribing opioid medications from the ED:

- i. The ED provider should attempt to contact the primary opioid prescriber. The patient's primary opioid prescriber should approve further opioids for the patient. If approved, a limited prescription, not to exceed a five-day supply, may be prescribed from the ED to last until the patient is able to see their primary opioid prescriber. If more medication is necessary, the patient's primary opioid provider can prescribe it during office hours. This reinforces the idea that patients should obtain pain medicine only from the primary opioid provider.
- ii. If the primary opioid provider cannot be reached, then the patient's pharmacy should be contacted. The pharmacy should verify recent prescriptions for pain medication from the primary opioid prescriber and confirm that prescriptions are not from multiple prescribers. The ED provider should confirm that recent opioid prescriptions reported by the pharmacy match what the patient reports. Unless necessary for patient stabilization as required by EMTALA (as described below in the legal consideration section), opioids should not be prescribed if the patient misrepresents the opioid prescriptions. Providing false information in an effort to obtain prescription opioids is an aberrant medication-taking behavior that can signal an addiction or illegal drug diversion activity.
- iii. Where the primary opioid provider cannot be reached, only prescribe enough opioid pain medication to last until the patient can contact his or her primary

prescriber. In following this recommendation, the maximum prescription should not exceed a five-day supply of opioids or as further outlined in recommendation #9 below.

- b. Supporting literature: Jena, et al., *BMJ*, 2014; 348: g1393; Hall, et al., *JAMA*, 2008; 300: 2613-20.

**6. Emergency Department providers should not provide prescriptions for controlled substances that were lost, destroyed, or stolen. Further, Emergency Department providers should not provide doses of methadone for patients in a methadone treatment program, unless the dose is verified with the treatment program and the patient’s ED evaluation and treatment has prevented them from obtaining their scheduled dose.**

- a. The goal of this recommendation is to help control against patients who are misusing controlled substances and may report their prescriptions as having been lost or stolen in an attempt to obtain more pills. The American Pain Society’s Agreement for Long-term Controlled Substances Therapy for Chronic Pain stipulates that “medications may not be replaced if they are lost, get wet, are destroyed ... etc.” The ED should institute a similar recommendation to not replace prescriptions for opioid analgesics requested based solely on the patient description of the drug being lost, stolen, or destroyed. ED providers, using professional medical judgment, may prescribe or offer an on-site dispensing of a single medication dose as a reasonable option. While this should be rare, in such a scenario ED providers should document that they confirmed the need directly with the patient’s primary provider. Pursuant to this recommendation, ED providers should not replace these prescriptions if they are unable to obtain this confirmation.
- b. As a reminder, when prescribing or administering narcotics, all providers must abide by current Drug Enforcement Administration (DEA) requirements. In particular, physicians should be aware of the specific regulatory requirements for physicians who are specifically administering methadone (a schedule II drug) or other buprenorphine products (schedule III drugs) for the treatment of opioid use disorder.
  - i. Under federal regulations, only a physician who is an employee or an agent of a registered narcotic treatment program can administer or dispense methadone for the treatment of opioid use disorders. Further in Massachusetts, these treatment programs (also known as Methadone Maintenance Treatment Programs), must be properly licensed by the Department of Public Health. On the other hand, buprenorphine products can be prescribed by physicians under the Drug Addiction Treatment Act of 2000 (DATA 2000) “Waiver Authority for Physicians Who Dispense or Prescribe Certain Narcotic Drugs for Maintenance Treatment or Detoxification Treatment” (H.R. 4365, Children’s Health Act of 2000). Those physicians are required to complete eight hours of training as part of the requirements and obtain an “X” license from the DEA.
  - ii. Exemptions:<sup>1</sup>

---

<sup>1</sup> 21 CFR 1306.07



1. Any other physician, such as an ED provider, is allowed to administer (but not prescribe) methadone and other narcotic drugs, such as buprenorphine products, for the purpose of relieving acute withdrawal symptoms, when necessary, while arrangements are being made for referral for treatment upon discharge. However, the federal regulations require that not more than one day's medication be administered to the person at one time and such emergency treatment may not occur for more than three days. This three-day limitation may not be renewed or extended.
  2. Additionally, pursuant to DEA regulations, a physician or other authorized hospital staff may administer or dispense narcotics (e.g. methadone or buprenorphine products) in a hospital, including in the ED, to maintain or detoxify a person as long as opioid use disorder diagnosis is incidental to the medical or surgical treatment of conditions, or for a patient with intractable pain where no relief or cure is possible or none has been found after reasonable efforts.
- c. This recommendation's goal should be for the ED provider or the admitting physician to call the methadone treatment program or the buprenorphine product provider prior to administering certain narcotics or before the patient is admitted to the hospital. The patient's status in the methadone or buprenorphine product treatment program should be verified and the dose should be documented for continued dosing while hospitalized. All methadone clinics should have a 24-hour contact line. The ED provider should consider that the patient may have been discharged from a methadone or buprenorphine product treatment program for noncompliance or may have not been attending the program. ED providers should know that methadone that is dispensed from a methadone maintenance program for treatment of opioid use disorder will not show up at the Massachusetts Prescription Monitoring Program.
- i. In the majority of cases, for treatment of opioid use disorder, methadone and buprenorphine products are prescribed to be taken once daily. For patients who are on this daily regimen, the withdrawal symptoms are not expected to start before 24 hours after the last dose. ED providers should know that opioid withdrawal is not generally recognized as an emergency medical condition, but missing daily maintenance dose can cause cravings and lead to relapse. The ED providers may also be aware that there may be a small group of patients who take these medications twice a day for various clinical reasons as directed by their providers. When ED providers call the treatment programs to confirm dose, they should also verify the directions of usage for these medications.
  - ii. Please be aware that most patients in a methadone treatment program must receive their dose daily and in person, supervised at the clinic. Some patients who are in sustained remission and compliant with treatment are allowed to have take home privileges, meaning they may have few days' worth of methadone at home. The ED providers should take this fact into consideration when planning for aftercare.
- d. When an ED provider sees a pattern of opioid pain medications for a patient that rises to a level of concern, the provider should engage the patient in a conversation about his or her prescription history in a non-accusatory conversation. A pattern of concern does not

always equate to substance misuse. Providers are encouraged to seek training on having difficult conversations with patients. The ED provider should seek the help of other hospital clinicians if he/she does not feel capable of having a conversation about the patient's prescription history and/or if the ED provider does not feel capable of having an intervention-type conversation; however, in most cases the provider should still be in the room for that conversation. It is also recommended that buprenorphine products should not be substituted for methadone as administration may result in sudden and severe opioid withdrawal.

- e. Supporting literature: Chabal, et al., Clin. J. Pain 197; 13: 150-55; Wu, et al., J. of Pain and Symptom Management, 2006; 32: 342-46

**7. Unless otherwise clinically indicated, Emergency Department providers should not prescribe long-acting or controlled-release opioids, such as OxyContin®, fentanyl patches, and methadone.**

- a. The task force strongly believes that the most appropriate treatment may be to refer a patient with chronic and complex pain to a pain specialist. However, there may be instances where an ED provider's professional medical judgment indicates deviation from this recommendation given a specific patient's circumstance and medical condition. Although expected to be rare, if the treating ED provider believes that long-acting or controlled-release opioids are necessary to stabilize a patient's severe pain, there are considerations that may influence the length of prescription (many of which are outlined in recommendation #9). These considerations may include the patient's medical condition or certain circumstances (e.g. state of emergencies, certain weather conditions, etc.) where it may be difficult to obtain follow up care within a few days. Providers should consider all relevant information about the patient and his or her situation in deciding on a course of treatment and/or prescription length.
- b. Long-acting or controlled-release opioids may be inappropriate for the treatment of acute or intermittent pain. These medications may cause death from respiratory depression in patients who have not taken opioid medications before, even when taken as directed. Some of these medications are *only* appropriate for patients who have become tolerant to opioids, underscoring the importance of an ongoing treating relationship. Often as a condition precedent to prescribing these medications, patients must agree to and sign a medication contract. These medications require close monitoring and follow-up care by a treatment provider; given the nature of ED care, the ED may be an inappropriate setting to prescribe such medications.
- c. Supporting literature: Hall, et al., JAMA, 2008; 300: 2613-20; Paulozzi, Am. J. Pub. Health, 2006; 96: 1755-1757.; Dhalla, et al., CMAJ, 2009, 181; 2: 891-896.

**8. When opioid medications are prescribed, the Emergency Department staff should counsel the patient:**

- to store the medications securely, not share them with others, and dispose of them properly when their pain has resolved;
- to avoid using the medications for non-medical purposes, and
- to avoid using opioids and concomitant sedating substances due to the risk of overdose.

- a. Providers should always discuss with patients the generally known risks and benefits associated with treatment and self-care post-discharge. To assist providers with this discussion, the task force developed a patient information sheet that can be used by each facility, which is located at the MHA substance abuse task force website (<http://www.mhalink.org/Content/NavigationMenu/Newsroom/SubstanceAbuse/default.htm>)
- b. Issues to consider for the discussion include:
  - i. Patients can be high risk for multiple reasons. Patients may be at risk for substance misuse or addiction, for interaction reasons, including but not limited to those who have co-morbidities (psychiatric and/or physical health) and those who are on benzodiazepines.
  - ii. The ED staff should ensure that prior to prescribing opioid medication, patients are thoroughly informed of the potential risks and potential benefits of the proposed opioid treatment, other alternative treatment(s), and no treatment.
  - iii. Patients should be counseled that the medication should be used only as directed and only until other non-opioid pain medication can be used to treat their pain.
  - iv. Once the patient can treat the pain with non-opioid medication, any remaining medication should be disposed of properly.
    1. The FDA provides guidance on safe disposal is available at: <http://www.fda.gov/downloads/Drugs/ResourcesForYou/Consumers/BuyingUsingMedicineSafely/UnderstandingOver-the-CounterMedicines/ucm107163.pdf>
    2. A patient-friendly sheet from the EPA is available at: <http://water.epa.gov/scitech/swguidance/ppcp/upload/ppcpflyer.pdf>
    3. The Massachusetts DPH's Bureau of Substance Abuse Services (BSAS) provides a list of prescription drop boxes where anyone can deposit unused medications safely: <http://www.mass.gov/eohhs/docs/dph/substance-abuse/opioid/ma-cities-and-towns-with-prescription-dropboxes.pdf>
    4. Also, most retail pharmacies sell special containers (e.g. envelopes) in which patients can mail unused medications to a licensed, secure facility where they are safely destroyed.
  - v. Risks of inappropriate opioid medication use that the provider should discuss with the patient include, but are not limited to:
    1. Developing tolerance, dependence, and/or addiction;
    2. Withdrawal symptoms;
    3. Overdoses that can lead to slow/stopped breathing, which can lead to death. Providers may wish to discuss the signs of respiratory depression in detail and what should be done if this happens;
    4. Propensity of fractures from falls for patients 60 and older (or for those who have fragile bones);

5. Drowsiness or other effects that impair the ability to operate vehicles and machinery, which can lead to injury; and
  6. Interactions with other drugs that may enhance or intensify the effects of opioids and/or increase the risk of overdose (i.e. alcohol, antihistamines, barbiturates, benzodiazepines, etc.)
- c. Supporting Literature: Dart, et al., *Annals of Emergency Medicine*, 2009; 53: 419-424; Wolf, et al., *J. Forensic Sciences* 2004; 49: 1-4.

**9. As clinically appropriate and weighing the feasibility of timely access for a patient to appropriate follow-up care and the problems of excess opioids in communities, Emergency Department providers should prescribe no more than a short course and minimal amount of opioid analgesics for serious acute pain, lasting no more than five days.**

- a. While this recommendation aims to set a general standard of prescribing opioid pain medication, no recommendation can override a provider's professional medical judgment to determine the right course of treatment (including prescribing practices), based on a patient's medical condition and circumstances surrounding the ED visit. While most ED patients legitimately seek pain relief treatment occurring from injury or exacerbations of other conditions, this recommendation seeks to affect people seeking opioid pain medications for improper use, such as recreational use, to feed an addiction, or to sell.
- b. There may be some acute conditions, e.g. rib fractures, for which severe pain is expected to last more than five days and for which risks of inadequate pain control may exceed the risks of a longer supply. In addition, there are certain circumstances (e.g., weather conditions, state or national disasters/emergencies, among others) that may warrant the prescribing of medication for a longer period of time due to the inability of the patient to access a pharmacy or to make an appointment with his or her primary care provider. Similarly, providers may consider regional wait times for certain specialists or primary care especially if the patient does not have a current primary provider, along with other factors, in determining adequate quantity of medication.
- c. While this recommendation provides a suggested limit on the number of days that opioids are prescribed from the ED, there is nothing to prevent a facility from developing a recommendation that includes a shorter period (e.g., 3 days) or a minimum number of pills.
  - i. Generally, many patients only need five days of medication, allowing them to make an appointment with a primary care or another appropriate provider. After five days the patient's condition should be reevaluated by their primary opioid prescriber or primary care provider to confirm the need for additional medication, both in quantity and dose, or to be switched to a non-opioid pain reliever (or non-medication treatment). If the pain persists, the patient may need to be admitted as an inpatient.
  - ii. When considering the quantity of pills prescribed, it is important to take as-needed dosing into account to ensure the minimal amount of pills is being prescribed from the ED. For example, a patient taking opioid medications "every six hours as needed for pain" may need only one or two doses a day.

- d. Prescribing more medication than necessary increases the risk for misuse, diversion, or development of substance use disorder. Additionally, patients who are not properly educated on the risks of opioids, or who aren't appropriately monitored, may use them for longer than necessary.
- e. Supporting literature: Dhalla, et al., *Canadian Family Physician*, March 2011, 57: 3:e92-e96; Alam, et al., *Arch. Intern. Med.*, 2012, 172(5): 425-430; Bohnert AB, Valenstein M, Bair MJ, et al. Association Between Opioid Prescribing Patterns and Opioid Overdose-Related Deaths. *JAMA*. 2011;305(13):1315-1321. doi:10.1001/jama.2011.370.  
<http://jama.jamanetwork.com/article.aspx?articleid=896182>

### **Operational Considerations:**

- Some hospitals in Massachusetts have already or are planning to adopt more restrictive operational versions of the nine recommendations as they believe is necessary to protect patients and provide excellent patient care. Such efforts are consistent with the goals of these guidelines. Hospitals are encouraged to assess their own population needs and to implement more restrictive policies if necessary. The objective of these guidelines is to ensure responsible and appropriate prescribing by all hospitals.
- It should be recognized that no recommendation can anticipate all circumstances. As described above, there may be circumstances where clinical information and provider professional judgment would dictate deviance. In these rare instances, there should be a record of the circumstances to help guide future considerations or changes. Examples of special circumstances that would warrant different application includes:
  - During situations of declared national, state, or local emergencies, providers may need to follow a different approach to some or all of the nine recommendations based on their professional medical judgment or because they must follow legal/regulatory mandates. For example, a provider may prescribe a larger dose of medication due to the patient's inability to access a pharmacy or make a primary care appointment, stemming from the emergency.
  - If a hospital has adopted more restrictive operational versions of the nine recommendations, providers would need to deviate from the recommendations in this document.
- Each ED should identify a champion(s) who ensures that ED providers are educated and trained on the recommendation. EDs should consider identifying a champion in various professional disciplines within their department, i.e. a physician, an advanced practice nurse, a registered nurse, a social worker, etc. The champion(s) should serve as a resource for anyone who has questions about the recommendation and its implementation. ED providers should be encouraged to take continuing education credits on topics relating to opioid pain medication use and treatment, substance misuse and substance use disorder, and other related topics.
- Good communication is essential between ED and inpatient providers. Where the patient will be admitted, the ED and inpatient providers should coordinate so that patient expectations are managed and treatment protocols are consistent throughout the patient's hospital encounter. If the patient has been screened for potential misuse issues or substance use disorder, especially if the screen was positive, this should be brought to the inpatient providers' attention.

- Departments are encouraged to obtain provider prescription usage reports from the PMP to identify practice variations. These reports do not need to be used in a confrontational way or for an adversarial process, though departments may need to take disciplinary action if necessary. Data on prescribing levels should be periodically shared among peers and department chairs (or other appropriate personnel). An appropriate person should facilitate discussion around cases that a provider may have found challenging, best practices in prescribing for various conditions/patients, and to encourage peer-to-peer education. This also provides each prescriber with an understanding of how his or her prescribing practice aligns with peers.
- Hospitals appreciate that some providers may feel pressure to prescribe medications to a patient for fear of complaints and impacts to patient satisfaction scores. Having all EDs in Massachusetts adopt this recommendation will establish a common practice that, if adhered to, will normalize any anticipated ramifications from not prescribing certain medications. Additionally, current research demonstrates that patient satisfaction scores are not based on whether the patient is provided or prescribed pain medications (opioid or otherwise). Other factors are more important. Hospitals should equip providers with training and resources to have difficult conversations with patients relating to opioid medications.
  - Some free resources available include the SCOPE of Pain, a CME/CNE web-based 3-module activity to help providers manage the prescribing of pain medications and treatment of chronic pain patients, available at: <https://www.scopeofpain.com/>. SCOPE of Pain has a list of clinical resources ranging from videos to pain medication information to assessment tools and those are available at: <https://www.scopeofpain.com/tools-resources/>.
- **If any documentation is prepared to be shared with the patients, additional policies and procedures should be implemented to avoid the risk that the material will be prematurely presented to the patient causing the patient to feel intimidated or leave the ED prior to screening and stabilization.** Template patient informational sheets have been developed to help with implementing the recommendations in this guideline, but as a general rule it is important that hospitals: 1) DO NOT post signs in the ED waiting or triage area regarding prescribing policies or stating any restrictions on prescribing opioid medications; and 2) DO NOT discuss any prescribing policies with ED patients until after they have received a medical screening examination.

### **Common Definitions to Consider:**

Providers should strive to use the most current professional language for medical conditions to facilitate optimal communication between providers. Also, using proper language and avoiding negative language may help reduce stigma and promote treatment. (Supporting literature: Kelly, et al., Am. J. Med., 2014, Stop Talking Dirty, Letter to the Editor.)

- 1) “Extended release long-acting opioids” (Chapter 17, Section 13 of the General Laws) shall mean a drug that is subject to the United States Food and Drug Administration’s risk evaluation and mitigation strategy for extended release and long-acting opioid analgesics and the term “non-abuse deterrent opioid” shall mean an opioid drug product that is approved for medical use but does not meet the requirements for listing as a chemically equivalent substitute pursuant to this section.

- 2) “Opioid analgesic” is meant to include medication formulations that include: oxycodone, hydrocodone, morphine, codeine, hydromorphone, oxymorphone, tramadol, methadone, fentanyl, and related compounds.
- 3) “Long acting formulation” is meant to include any opioid medication that has duration of action of greater than 4 hours, or any formulation designed to extend the duration of action of a given opioid analgesic.
- 4) “Physical dependence” is a state of adaptation manifested by a drug class-specific withdrawal syndrome that can be produced by abrupt cessation, rapid dose reduction, decreasing blood level of the drug, and/or administration of an antagonist.
- 5) “Tolerance” is a state of adaptation in which exposure to a drug induces changes that result in a diminution of one or more opioid effects over time.
- 6) “Addiction” is a primary, chronic disease of brain reward, motivation, memory and related circuitry. Dysfunction in these circuits leads to characteristic biological, psychological, social and spiritual manifestations. This is reflected in an individual pathologically pursuing reward and/or relief by substance use and other behaviors. Addiction is characterized by inability to consistently abstain, impairment in behavioral control, craving, diminished recognition of significant problems with one’s behaviors and interpersonal relationships, and a dysfunctional emotional response. Like other chronic diseases, addiction often involves cycles of relapse and remission. Without treatment or engagement in recovery activities, addiction is progressive and can result in disability or premature death (American Society of Addiction Medicine: [www.asam.org/for-the-public/definition-of-addiction](http://www.asam.org/for-the-public/definition-of-addiction)).
- 7) “Misuse” is the use of a medication (for a medical purpose) other than as directed or indicated, whether willful or unintentional, and whether harm results or not.

### **Legal Consideration:**

To ensure the appropriate adoption of these guidelines, hospital staff should discuss with their medical staff, clinical leadership, and legal counsel the potential impact it may have on hospital EMTALA obligations – the federal Emergency Medical Treatment and Active Labor Act. EMTALA requires an appropriate medical screening examination for any individual who presents at a hospital with an ED and when a request is made for examination or treatment of a medical condition. If the hospital determines that a patient has an emergency medical condition, the hospital must provide either treatment as may be required to stabilize the patient’s medical condition or transfer to another medical facility pursuant to the EMTALA laws and regulations. As part of the EMTALA guidance from the federal government, it is important to note that an emergency medical condition includes severe pain. However, EMTALA *does not* mandate the use of any particular treatment modality, including opioid medication, and the law still provides that it is up to the professional medical judgment of the ED provider in recommending treatment decisions that are required to stabilize the emergency medical condition. As in other areas of medical practice, it is sometimes appropriate for medical professionals (in the exercise of that judgment) to develop (individually or collectively) consistent approaches to common problems, including the appropriate use and management of opioid medication. There are some CMS regional offices (not Region 1 in New England) that have raised an EMTALA-based concern about hospitals posting or distributing descriptions of policies or approaches *before* the patient is given an appropriate medical screening examination so that patients with actual emergency medical conditions will not be unduly discouraged from remaining in the ED for an appropriate medical screening examination. CMS has acknowledged, however, that a

discussion of any opioid management can appropriately occur during or after the medical screening examination. To meet this concern and to reiterate the point made above, **it is recommended that hospitals not post any statements that would be seen as refusing to provide patients with opioid medications if they present with severe pain, thereby causing the patient to leave the ED prior to receiving a medical screening exam and stabilization.** Nothing in this document is intended to interfere with or supersede the professional medical judgment of the provider, nor the clinical and administrative policies of the hospital. Rather, this is intended to provide guidance to clinical staff when seeking to provide the best and safest care to patients within the Emergency Department only.